Newton Parks and Recreation Summer Programs

Child's Name: _____

Camps Attending: _____

Please list all of the Newton Parks and Recreation Summer Programs your child will be attending so we can photocopy the paperwork for each program.

PAPERWORK NEEDED

Please email this paperwork to the camp your child is attending, or mail it to **Newton Parks and Recreation at 246 Dudley Road, Newton, MA 02459**

_____**Release Form**

_____**Identification/Emergency Information** (2 pages)

_____**Physical Form** (2 pages) if your doctor's office has a standard medical examination print out for summer camps you may attach that in lieu of this from. Examinations must be dated within 1 year of your child's participation at camp. If your child has a summer physical scheduled, please submit your current physical until you receive the new form.

_____**Medication Forms** (only if needed) if your child will be taking daily medications at camp, or if they will be bringing an inhaler or epi pen to camp, please make sure you fill out these forms. Newton Parks and Recreation Camp Health Supervisors are only allowed to administer oral medications.

All paperwork and balances must be submitted by May 15th. A $25.00 late fee will be assessed for all late paperwork and payments.

You can pay your balance online with a Visa or Mastercard. To do this, go to www.activityreg.com and click on Massachusetts, then Newton Parks and Recreation. In the top right hand corner click on Login and you will be able to access your family account.

NEWTON PARKS AND RECREATION DEPARTMENT

RELEASE

Kids Korner Summer Program

I/We, the undersigned, as parent(s) or guardian(s) of_____, a minor, do hereby consent to his/her participation in and field trips with the Kids Korner Summer Program. In signing this consent, I/we do forever RELEASE, acquit, discharge and covenant to hold harmless the City of Newton, a municipal corporation of the Commonwealth of Massachusetts, and its successors, departments, officers, employees, servants, and agents, of and from any and all actions, causes of actions, claims, demands, damages, costs, loss of services, expenses, and compensation on account of , or in any way growing out of , directly or indirectly, all known and unknown personal injuries or property damages which I/we may not or hereafter have as the parent(s) or guardian(s) of said minor, and also all claims or rights of actions or damages which said minor has or hereafter may acquire, either before or after his/her participation in the Kids Korner Summer Program. FURTHERMORE, I/we hereby agree to protect the City of Newton and its successors, departments, officers, employees, servants and agents against any claim for damages, compensation or otherwise on the part of said minor growing out of or resulting from injury to said minor in connection with his/her participation in the said Kids Korner Summer Program and/or field trips with the Kids Korner Summer Program and to INDEMNIFY, reimburse or make good to the City of Newton or its successors, departments, officers, employees, servants and agents any loss or damage or costs, including attorney's fees, the City or its representatives may have to pay if any litigations arise from said minor's participation in the said Kids Korner Summer Program.

_____ _____

SIGNATURE OF PARENT(S) OR GUARDIAN(S) RELATIONSHIP DATE

THIS FORM MAY NOT BE ALTERED

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NEWTON PARKS AND RECREATION DEPARTMENT

MEDICAL RELEASE AUTHORIZATION & CONSENT FORM

I/We understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. (Child's Name)_____.

However, if I/We cannot be reached, I/We hereby authorize the KIDS KORNER SUMMER PROGRAM to transport my child to Newton-Wellesley Hospital, or_____Hospital, or nearest hospital (via Ambulance Service), to secure for my child the necessary medical treatment.

I/We understand that designated staff members at KIDS KORNER SUMMER PROGRAM are trained in the basics of First Aid, and Cardiopulmonary Resuscitation, and I authorize them to administer immediate First Aid to my child when appropriate.

_____

PRINT PARENT/GUARDIAN NAME **SIGNATURE** PARENT/GUARDIAN

_____ _____ _____

DATE **HEALTH INSURANCE CO:** **CHILD'S POLICY #**

_____ _____

PHYSICIAN'S NAME **PHYSICIANS PHONE #**

****

PHOTO RELEASE

I/We hereby grant permission for my child's picture to be taken with the possibility of its being published, reproduced, or otherwise used for publicity, educational, or other purposes related to the KIDS KORNER SUMMER PROGRAM.

CIRCLE ONE YES NO

_____

PARENT/GUARDIAN SIGNATURE DATE

NEWTON PARKS AND RECREATION DEPARTMENT
KIDS KORNER SUMMER PROGRAM

CAMPER INFORMATION

PLEASE TAKE THE TIME TO COMPLETE THE FOLLOWING QUESTIONS SO WE MAY BETTER SERVE YOUR CHILD AT CAMP.

SOCIAL RELATIONSHIPS:

Has your child had experiences playing with other children? _____

By nature is child friendly _____ aggressive _____ shy _____ withdrawn _____

How does your child relate to strangers? _____

Does your child play well alone? _____ What is your child's favorite toy? _____

Is your child frightened by: Animals _____ Rough children _____ Loud noises _____
Dark _____ Storms _____ Anything else _____

Who and how is your child disciplined? _____

EATING:

Does your child have any eating problems? _____

Food Allergies _____ Favorite foods _____

Refuses food _____ Does child eat with a Spoon _____ Fork _____ Hands _____

TOILET HABITS:

Does your child indicate bathroom needs? _____ Word for Urination? _____

Word for bowel Movement? _____ Is child frightened of the bathroom? _____

Does child have accidents? _____

SLEEPING HABITS:

Does your child take naps? _____ From when _____ to _____?

What time does your child go to bed in PM? _____ Awaken in AM? _____

Mood on awakening? _____ What does your child take to bed? _____

GENERAL:

Please list some of your child's likes and interests: _____

Please use this space to elaborate upon anything which will help the staff better understand your child:
_____
_____
_____
_____

NEWTON PARKS AND RECREATION DEPARTMENT
SUMMER PROGRAMS
MEDICAL EXAMINATION

Please Note: Many doctor's offices have a standard medical examination print out for summer camps. These forms will be accepted in lieu of this medical examination from as long as they have all of the below information. Examinations must be dated within 1 year of your child's participation at camp.

Name_____ Birth Date _____

Age _____Sex____ Grade Entering_____ School _____

Parent/Guardian
_____

Home Address
_____

Home Phone _____ Work_____ Cell _____
Home Phone_____ Work_____ Cell _____

Emergency Contact_____ Relationship_____

Home Phone_____ Work_____ Cell_____
****

HEALTH HISTORY: To be filled out by a licensed physician. This examination should be performed within one year of the starting date of this program. Check if appropriate and give approximate dates.

ASTHMA_____ATHLETES FOOT_____ CHICKEN POX _____

MUMPS_____ MEASLES_____ SINUSITIS _____

POLIO_____ FAINTING_____ CONSTIPATION _____

FREQUENT COLDS_____ EAR INFECTIONS_____ SORE THROATS
_____

GLASSES_____ VISION PROBLEMS_____ HEAD LICE_____

WHOOPING COUGH _____OPERATIONS_____

STOMACH TROUBLE_____ HEART
TROUBLE_____

SEIZURES (type and frequency)

IMMUNIZATION HISTORY: This is a record of dates of basic immunizations and most recent booster doses. This must be completed in full prior to the start of the program.

DPT SERIES_____ /_____ / _____DPT BOOSTER _____

TETANUS_____ TETANUS BOOSTER_____ / _____/ _____

POLIO/OPV SERIES_____ POLIO BOOSTER _____

MEASLES (2 live doses necessary after 12 months) _____/ _____

MUMPS _____RUBELLA _____

MMR_____ MANTOUX TEST _____

HEPATITIS B_____ /_____ / _____

****

ALLERGIC REACTIONS:

BEE STINGS _____PENICILLIN_____OTHER _____

FOOD ALLERGIES _____

CURRENT MEDICATIONS _____

ANY RESTRICTIONS _____

****

The above information contained in the immunization and Health History is correct to the best of my knowledge. The person herein described is in good physical health and has my permission to engage in all prescribed program activities, except as noted above. This form must be signed by a Physician with respect to immunization history.

_____ _____

PHYSICIAN'S SIGNATURE **DATE**

PHYSICIANS ADDRESS _____

PHYSICIAN'S PHONE NUMBER_____